Application for Crime Victim Compensation

(Please print clearly and fill out both sides.)

Victim's Name: _____ Soc. Sec. #

(First) (Middle) (Last)

Address: _____

(Note: The Crime Victim Compensation Program will send mail to this address. If you do not want mail sent to your home address, please provide an alternative mailing address.)

City/State: _____ Zip Code: _____ Phone:

Your Name: _____ Your Relationship to victim: ___

(If victim is minor or deceased.)

Your Address: _____ City/State: _____ Zip: ___

(If different than victim's.)

Victim's date of birth: _____ Your Soc. Sec. #: _____

Type of Crime:
- ☐ Assault (non-familial)
- ☐ Homicide
- ☐ Sexual Assault
- ☐ Child Sexual Assault
- ☐ Child Physical Abuse
- ☐ Drunk Driving
- ☐ Domestic Violence
- ☐ Hit & Run
- ☐ Other (please explain)

Optional:
The following victim information is used for statistical purposes only. It is used only to comply with federal regulations.

Disabled: ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Age: ☐ 17-under ☐ 18-63 ☐ 64-over

Race: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Asian/Pacific Islander ☐ Other

Who referred you? Police Office of the Attorney General Hospital Victim Services Other

Law enforcement agency crime reported to: _____ Case #: _____

Exact location of crime: _____ Investigating Officer: _____

Date of crime: _____ Date crime reported: _____ Date crime discovered: ___

Name of person(s) who committed crime: _____

Does the victim have children or other dependents? ☐ Yes ☐ No

Did the victim miss work as a result of crime- related injuries? ☐ Yes ☐ No

Does the applicant wish to apply for an emergency award for burial expenses? ☐ Yes ☐ No

Employer's Business Name _____ Contact person/Phone number _____

Street Address _____ City/State/Zip _____

Check those expenses for which you are requesting compensation:
- ☐ Lost wages for victim
- ☐ Loss of support for dependent of a deceased victim
- ☐ Medical expenses for victim
- ☐ Dental expenses
- ☐ Counseling for the victim
- ☐ Counseling for homicide victim survivors (parent, spouse, minor sibling or minor child.)
- ☐ Funeral and burial

Insurance Information: ☐ Car ☐ Medicaid/Medicare ☐ Workers Comp ☐ Health ☐ None

Name, Address & policy #:

Are you represented by a private attorney in a civil law suit or insurance action? ☐ Yes ☐ No ☐ Not at this time

Attorney's Name: _____ Phone _____

Address: _____ City/State/Zip: _____

YOU MUST READ AND SIGN BELOW AS NEEDED

Briefly describe the crime and the injuries that resulted:

List names of any doctors, clinics, hospitals dentists, ambulance, etc.
(Send bill copies if available. Use more paper for list if needed.)

Name	Address, City, State, Zip	Telephone

REPAYMENT AGREEMENT

I understand the Victim Compensation Fund is a FUND OF LAST RESORT. I understand that Rhode Island law requires me to contact and repay the Crime Victim Compensation Program if I receive payments from the offender, a civil law suit, an insurance program, Government or private agency, or any other source after I receive payment from the Crime Victim Compensation Program. I agree to notify the Crime Victim Compensation Program if I hire an attorney to represent me in any action related to this crime.

X _____ Date _____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize any hospital, medical facility, doctor, mental health provider, employer, insurance company, person or agency to give needed information to the Crime Victims Compensation Program. I understand that the information will only be used to determine compensation benefits. I understand that any records are protected under the federal confidentiality regulations and under the general laws of the state of Rhode Island and can not be disclosed without my written consent except as otherwise provided by law. Any information released or received as a result of this consent shall not be further relayed in any way to any other person, organization, entity or other, without an additional written consent by me. I may withdraw this consent by giving written notification to the above party at any time prior to the disclosure or the release of the information. I authorize that a photostat copy of the original of this authorization be accepted with the same authority as the original.

I certify that the information and supporting documentation contained in this application is true and accurate to the best of my knowledge.

X _____ Date _____

Return completed Application to:
Crime Victim Compensation Program
Office of the General Treasurer
40 Fountain Street
Providence, RI 02903